Michigan Department of Community Health
Jennifer M. Granholm, Governor
Janet Olszewski, Director

Michigan Department of Community Health
Medical Services Administration

CMS Conference Call

NOTES

Date:	March 15, 2006
Time:	1:00 p.m.
Where:	Capitol Commons – Conference Room 7C 400 S. Pine Lansing, MI 48933
Conference Call Attendees:	Linda Tavener (CMS/CO Division of Reimbursement & State Financing), Mary Cieslicki (CMS/CO Division of Reimbursement & State Financing), Chris Thompson (CMS/CO Division of Reimbursement & State Financing), Melissa Harris (CMS/CO Division of Integrated Health Systems), Angela Corbin (CMS/CO Division of Integrated Health Systems), Maria Reed (CMS/CO Division of Integrated Health Systems), Ellen Blackwell (CMS/CO Division of Benefits & Coverage), April Forsythe (CMS/CO Division of Benefits & Coverage), Sharon Brown (CMS/CO Division of Financial Management)(Adm. Claiming), Judi Wallace (CMS/CO Division of Financial Management)(Adm. Claiming), Julie Greenway (CMS Local Office), Mary Ann McGuire (CMS Local Office), Tom Caughey (CMS Local Office), Paul Reinhart, Steve Fitton, Nancy Bishop, Ed Kemp, Toni Hornberger, Jane Reagan, Linda Sowle, Dave Stirdivant, Pam O'Farrell, John Shaughnessey (PCG), Sean Huse (PCG).

Purpose of Call:

- To discuss the procedures that CMS is following right now with respect to State Plan Amendments and Reimbursement methodologies that are tied to Certified Public Expenditures.istory
    - Many changes in CMS in the last 1 ½ years. The emphasis from CMS now is on the proper funding of the State Medicaid program.
    - 1st focus was on - Intergovernmental Transfers
    - 2nd on - Certified Public Expenditures (CPEs).

State Plan Amendment Review Procedure:

- CMS is now looking at companion parts of the State Plan whenever an amendment is submitted.
- Our SPA came under review because it was determined that the program was funded by CPEs. The state was mandated to develop a cost-based methodology with a certification process that meets the requirements that CMS has now established for CPEs.
- CMS will continue to work with us on the reimbursement methodology and cost report.
- Leadership at CMS has taken the position that for pending SPAs that are using CPEs they want to see resolution by the end of the current State's fiscal year. Asking that the states put sunset language in the SPA 04-02 indicating that the reimbursement methodology will sunset at the end of the state's fiscal year and that a new compliant process would take effect 10/1/06.
- **In addition leadership at CMS intends to put out policy (probably in a State Medicaid Directors letter) that will describe requirements for certifying public expenditures. And stating that states that don't meet those requirements as of the beginning of their next fiscal**

years will be at risk of loosing FFP related to those services. This will be an across the board policy.

- Ed brought up the fact that this is the direction we have been moving. CMS recognizes that much work has been done on the Reimbursement methodology but if both coverage and reimbursement are not acceptable by 9/30/06 FFP will be stopped.
    - Response: (Linda Tavener) said that the State could take the sunset right now which would allow CMS to approve the LPN SPA 04-02 and then the state could draw down FFP related to that SPA from 1/1/04 through 9/30/06. But the State would have to sign a voluntary sunset agreement that would be effective 10/1/06.
- Steve Fitton – Is it CMS's intent to surprise the other states with this mandate?
    - Response: (Linda Tavener) The leadership has decided that the beginning of the next fiscal year the new policy will take effect, and in order to use Certified Public Expenditures as the portion of your State share you will have to be compliant with cost-based, certified reimbursement methodology.
- Toni Hornberger – The State has been under the impression that the outcome of the reimbursement methodology was that the LPN SPA would be approved. Is this no longer the case?
    - Response: (Linda Tavener) In order for the reimbursement SPA to be accepted the coverage has to be reviewed first. They cannot approve the reimbursement before they know what coverage's are going to be offered.

Coverage (Ellen Blackwel/April Forsythe):

- There have been organizational changes at CMS. Maria Reed will be the new the contact for the State Plan coverage going forward.
- When SPAs come in there is a review of both sides of the SPA; coverage and reimbursement.
- Both coverage and reimbursement must be approvable in order for the SPA to be effective and draw down FFP as of 10/01/06.
- Michigan will need to answer the questions from CMS and will be getting a letter from Terry Pratt who is the deputy director saying that we need to submit the coverage pages that pertain to school based services. CMS wants to start working with the State right away to put the coverage in place.
- Most of the services should be able to stay in place but CMS has some questions on some of the coverages.
- If services are moved under EPSDT:
    - Michigan will loose those children from age 21 – 26,
    - Services must be Medicaid 1905 (a) allowable service,
    - Must be offered to everyone in EPSDT, or everyone in State Plan
    - The State cannot limit the services to the school setting.
- The State will need to tell CMS what the services are, who the providers are, and what the provider qualifications are.

Reimbursement:

- On the Reimbursement 4.19 b side:
  - There will have to be a reimbursement methodology for community providers and school based providers. This means that if the service is provided in the school CMS wants to compare the school reimbursement to that reimbursement received in the community setting.
  - Michigan has been waiting on a response from CMS on the Draft reimbursement methodology.
  - Response: (Linda Tavener) CMS cannot move forward on reimbursement methodology without reviewing the coverage sections. CMS feels that the coverage is driving reimbursement.
  - The State requested documentation of the issues CMS has with the coverage and reimbursement.
  - Response: (Linda Tavener) CMS feels it is quicker and more efficient to handle the questions via phone calls etc.
  - Toni – What is the status of the Technical Assistance Guide is? Michigan has built their services in accordance with the guide.
  - Response: (Linda Tavener) CMS feels that our services are inappropriately under the Rehabilitation section of the State Plan and that since these services are not restorative in nature they do not belong there. CMS defines rehabilitation according to 42 CFR 440.130 and feels that the services must be restorative not to ameliorate in order to qualify as rehabilitative.
  - CMS ask if services are available to all Medicaid beneficiaries.
    - The State responded that we offer another place of service and do not restrict the beneficiary from seeking services in any setting.
  - L T. - The only thing that is different about SBS is that Education pays after Medicaid, but all services must still be a covered service. SBS is just a payment variance.
    - For instance Developmental Testing; CMS is having problems understanding what kind of 1905 (a) services this is an how it could be delivered to everyone in the State Plan?
  - Steve F. - Was there a mistake made when the original State Plan was approved, since it has been in application for 15 years? Are you reviewing all of the states and finding similar problems?
  - Response: (Linda Tavener) CMS approved it but is now re-reviewing the services to make sure they are correct. They want to make sure that everyone who qualifies for the service is able to access it. Currently they are reviewing the plans as they come in but will be sending out a Medicaid director's letter. CMS will make every effort to review the draft SPA submissions the same day they are received.
  - CMS is giving us the date we have to work with. If the State feels that they have to have more time then they must send this to CMS with the reason why more time is needed and they will consider the request.
  - CMS needs to know which professional's salary and fringes are in the pot for reimbursement. Will ask who the providers are and that the coverage side has verified that this is a qualified provider to have their salaries and fringes included in the cost.

- The State will need to show the cost-based methodology plus show the comparable community setting rate.
- Schools can elect to serve only children with IEPs.
- For example Personal Care services
    - A Medicaid beneficiary can elect to get these services in the home, in school etc.
- Providers
    - If there are federal regulations in place the providers must meet the requirements of the federal regulations. They can also have supplemental qualifications, but must minimally meet the requirements of the federal regs.
- Concerns with reimbursement methodology.
- Need to check with Mary Cieslicki, who had just left. It was thought that her concern was with the cost report.

Issues:

- CMS would like the State to document their questions and submit through Julie.
- It is recommended that two calls be scheduled: One for the reimbursement issues and another for the coverage issues.